FOOT AND ANKLE CLINIC OF CENTRAL TEXAS

Patient Intake Form

We would like to welcome you to our practice. Please complete this form as accurately as possible so we can most appropriately address your healthcare needs.

The confidentiality of your health information is protected in accordance with federal protections for the health information under the Health Insurance Portability and Accountability Act (HIPAA).

Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing.

Please print all responses: Date:_____

Name:_____Age:_____
Last First Middle
Date of Birth:_____Sex:_____Race:_____Ethnicity:_____
Marital status: __single __married __separated __divorced __widowed
Address:_____
Street City State Zip code
Phone contact: Primary:_____Secondary:_____
Email:_____

Guarantor:_____
Social Security number:_____
Occupation:_____Employer_____

Primary Insurance:_____Policy:_____
Responsible party:_____Date of birth:_____
Social Security number:_____

Provide foot or ankle problem:_____
_____
_____
_____

Provide specific injury details including when and where:_____
_____
_____
_____

Name and address of primary care physician:_____

_____

Name and address of cardiologist(if applicable):_____

_____

Who referred you to our office:_____

Do you experience chronic pain? Yes No

If yes how is your pain managed (ie, physical therapy, medication, etc)?

_____

Surgeries:

Please list specific surgeries and dates

_____

_____

_____

_____

Patient Medical History:

Please check all that apply

__Heart Disease (type_____)

__Stroke (when_____)

__High Blood Pressure

__ High Cholesterol

__Diabetes (type ___ how long____)

__Venous Thrombosis

__ AIDS

__Hepatitis A

__Hepatitis B

__Hepatitis C

__Cirrhosis

__Anemia

__Thyroid Trouble

__Gallbladder Disease

__Ulcers (where)_____

__Cancer (type)_____

__Arthritis (type)_____

__Osteoporosis

__Fractures (where)_____

(when)_____

__Migraines

__Depression

__Anxiety or Panic Disorder

__Alcohol or Substance Use Problem

Other:_____

Family Medical History

Please check all that apply	Relationship
__Stroke	_____
__Heart Disease	_____
__High Blood Pressure	_____
__Kidney Disease	_____
__Diabetes	_____
__ Arthritis (type)	_____
__Osteoporosis	_____
__Migraine Headaches	_____
__ Cancer(type)_____	_____

System Review

Please check any of the following symptoms that you have recently experienced

General		
__Recent weight loss	__Recent weight gain	__fatigue
__fever	__Change in appetite	__night sweats
Skin		
__rashes	__lumps	__itches
__dryness	__color change	__hair/nail change
Cardiac		
__Heart murmur	__chest pain	__palpitations
__swelling of feet	__shortness of breath	
Musculosketal:		
__joint stiffness	__arthritis	__gout
__backache	__muscle pain	__muscle cramps
Peripheral Vascular		
__leg cramps while walking	__varicose veins	__thrombophlebitis
Neurological:		
__fainting	__blackouts	__seizures
__weakness	__numbness	__tremors
__tingling hands/feet	__change in memory	
Psychiatric/Psychological		
__anxiety	__depression	__phobias
__family problems	__eating disorder	
Hematologic		
__anemia	__easy bruising or bleeding	
Endocrine:		
__heat/cold intolerance	__excessive sweating	__excessive hunger
__excessive urinating		

Current Medications: **Pharmacy:**_____

Please include any non-prescription drugs as well, eg, vitamins, aspirin, etc

	Medication name	Dose	Frequency of use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Allergies:

Please list any allergies and reactions you may have to medications.

_____

_____

Substance use history:

Use of alcohol:

never rarely moderate daily

Use of tobacco:

never current smoker former smoker _____

Other: _____

Do you have an advanced health directive, such as do not resuscitate? Yes No

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care for you.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to preform the necessary services I may need.

Guarantor signature:_____ Date:_____